The Tasmanian Government

Enquiry into Concerns of Midwives at the Royal Hobart Hospital

Could Continuity of Midwifery Care and safe workloads be the key to mothers being safe heard and valued?

Thank you for the opportunity to comment upon concerns raised by the ANMF and past and current staff related to the safety and quality of maternity and paediatric care at the RHH. Thank you to Health Minister. Mr Guy Barnett for acknowledging that "the safety of mothers and babies is of paramount importance and the claims made by nurses and midwives through the ANMF and the media are very serious". It will be heartening to read the review by the review team, lead by Ms Amanda Singleton. It is also very encouraging to know that the government is committed to building a new mother-baby unit and in boosting funding to our valued neighbourhood centres.

In approaching your terms of reference, I first went for an early morning walk to enjoy the sight, at a respectful distance, of a mother plover perambulating her four new fluffy powder puff chicks that were tottering about happily on tiny stilt like legs; whilst a protective father plover hovered nearby. I reflected, well this is what it should be for new mothers, shouldn't it? Mother plover sat on the nest through storms, wind and rain and here she is empowered and protecting her new chicks!

I recently appreciated reading Julia Leinweber's team discussion on what is a woman centred, inclusive definition of a positive childbirth experience as

"A positive childbirth experience refers to a woman's experience of interactions and events directly related to childbirth that made her feel supported, in control, safe, and respected; a positive childbirth can make women feel joy, confident, and/or accomplished and may have short- and/or long-term positive impacts on a woman's psychosocial well-being."

https://pubmed.ncbi.nlm.nih.gov/35790019/#:~:te

However, It was sadly a red flag to find out via the media recently that some of our valued midwives are going home after their shifts at the RHH feeling anxious and worried about the birthing mothers and the newborn infants that they care for, and that specifically they worry about serious adverse events for mothers and babies. It is also a concern to learn that midwives are reporting feelings of exhaustion, tearfulness, failure, and burnout; and that some are considering leaving the profession. Midwives have historically been staunch advocates of mothers and babies; and moreover, feminist leaders in the empowerment of women. Even more reason to take their concerns seriously!

What is a woman-centred definition of a traumatic birth experience that is meaningful and inclusive? I appreciated reading the Open Access Article by Julia Leinweber et.al

" A traumatic childbirth experience refers to a woman's experience of interactions and/or events directly related to childbirth that caused

overwhelming distressing emotions and reactions; leading to short and/ or long-term negative impacts on a woman's health and wellbeing."

Developing a woman-centred, inclusive definition of traumatic childbirth experiences: A discussion paper - PubMed (nih.gov)

I also read the Australian Lawyers Alliance recent submission to the Tasmanian Government's Select Committee on Reproductive, Maternal and Paediatric Health Services in Tasmania.

It is valuable to reflect upon the 6 very sad and concerning de-identified case studies of maternal and baby birth trauma. I cried when reading about the preventable injuries to the mothers and their babies, and of the anguish of the parents where one baby died as a result of preventable birth trauma. I therefore agree completely with the ALA 's recommendations for the urgent need to address staffing and resourcing shortcomings as a matter of priority in the interests of public health and safety. I also agree with the ALA concerns about the need for improved communication and informed discussions and education to support ongoing and informed consent; and also, that there needs to be quality improvement in practice to reduce the routine use of instruments during delivery to prevent severe injuries to mothers and their babies.

https://www.parliament.tas.gov.au/__data/assets/pdf_file/

Let us look at a recent research paper by Australian midwives, Traumatic birth and childbirth-related post-traumatic stress disorder: International expert consensus recommendations for practice, policy, and research - ScienceDirect about traumatic birth and childbirth-related post-traumatic stress disorder. The researchers highlight that the experience of traumatic birth and childbirth related post-traumatic- stress disorder, is very serious and that one in three births are experienced as psychologically traumatic, and about 4% of women and 1% of their partners develop post traumatic stress disorder (PTSD) as a result. The authors conclude,

"Recommendations for practice include that care for women and birth partners must be given in ways that minimise negative birth experiences. This includes respecting women's rights before, during, and after childbirth; and preventing maltreatment and obstetric violence. Principles of trauma-informed care need to be integrated across maternity settings.

The authors also highlight the need for prevention of traumatic birth and childbirth related post traumatic birth disorder. I agree with their recommendation that it would be helpful for a comprehensive, holistic approach to mental health support be available for birthing women, their birth partners, families, and all involved in the childbirth process.

Apart from restoring required safe midwife staffing levels, better clinical governance, better resourcing, and education, could there be better access to mental health nurses in the perinatal period for all mothers and their partners to discuss their birth experience? Whilst there is some discussion in the literature as to how helpful this

could be, could talking through difficulties experienced and feeling heard and respected help women as midwives cited in the previous study have advocated?

Also, could there be universal access to a woman's health physiotherapist for all women in the perinatal period even where mothers report a positive birth experience? Moreover, do women have universal access to a breastfeeding or lactation consultant or infant feeding consultant in the perinatal period to affirm her choices and efforts? Is the RHH committed to retaining the valuable Migrant and Refugee CALD health worker specific position within the RHH Social Work team? Is there an institutional commitment to retain access to free and confidential accredited Interpreter services?

Also let us be very mindful that safe, educated, and aware multidisciplinary teamwork and communication; along with safe staffing levels are essential to help identify instances of domestic and family violence. Pregnancy and childbirth are times when women experience vulnerability. If she is experiencing coercive control or has experienced past or ongoing family or domestic violence, good communication, the development of trust, collaborative decision making, open communication and a continuity of care model can help to save the life of both mother and baby. Could a continuity of Midwife Care model where mothers feel safe heard and respected be the key?

https://pubmed.ncbi.nlm.nih.gov/38142159/#:~:text=This%20

I agree with Professor Marjula O'Connor, (Chair, RANZ College of Psychiatrists Family Violence Psychiatry network) that there could also be an opportunity to better identify and instances of family and domestic violence. For example, due to sexist stereotyping of women survivors of domestic violence as being passive, submissive, and co-operative with law enforcement, women may be misidentified as perpetrators of violence rather than resisters and survivors. Worse, within hospital settings, women can all too easily be labelled as "difficult" or be misdiagnosed as having "something wrong with her", when in fact the problem is coercive control or domestic/family violence.

This is even more the reason for ensuring that the culture of care and the communication with birthing women and the care that she and her baby receives is safe, respectful, and collaborative, and respectful of her autonomy.

In paediatric settings, young or new mothers of babies requiring care for sleeping and feeding difficulties, or for example, treatment of bronchiolitis can feel that suddenly everyone knows more about her infant than she does. Not only does she need affirmation that she knows her baby better than anyone else in the entire hospital, it is helpful if she can talk about her support both within the family home and community in confidence with a qualified Social Worker-one of the few people in the care team that actually does not have 'hands on her baby' and who can validate her efforts and normalise her fears and anxieties.

Also, for example, would she like more information about community supports? How does her partner support her? Would she like to link with a service such as Early Support for Parents to help navigate a difficult patch when everything can seem overwhelming? Does she have an understanding mother or grandmother or young friends who are navigating new motherhood alongside her with which to share her experiences? Are the Care by Parent facilities in the RHH adequate? For example, is there a provision for a new mother or parent to sleep comfortably alongside the baby (not in a chair please) or in a safe room with a door nearby? Also, given the cost-of-living crisis and housing affordability issue for many young Tasmanian families, please retain the Patient Travel Assistance Program and other supports to enable her to visit her baby at the hospital. (The views expressed in the above two paragraphs are those of members of Tasmanian branch of the National Council of Women)

Safe Workforce Standards in Maternity and Paediatric Settings.

A key concern of the current review led by Ms Amanda Stapleton comprises the duty of care to address staff shortages and to consider a safe staffing model for maternity and paediatric care. I agree with the ALA that there already exists a systemic gap between rural and urban areas in Tasmania regarding access to medical services that can disadvantage women contemplating pregnancy or who have had prior pregnancy or birth complications.

How encouraging it is to see the Tasmanian government consider incentives to encourage new doctors to step up into rural practice.

However, I also share concerns highlighted by ALA for women living with disability, and for women who identify as non- binary, aboriginal or from a culturally diverse background, and for young mothers. These women could be doubly disadvantaged from access to quality and trusted medical care due to a need for more doctors who use affordable bulk billing in their practice. Women need continuity of care, respect, and a shared decision-making model of communication with doctors and midwives and relevant allied health professionals.

Questions that we can consider relating to concerns about staffing shortages and the duty of care to maintain safe staffing levels, resourcing, and education in Maternity and Paediatric care at RHH.

1. What can we learn from how a crisis at one maternity service (about the 2015 cluster of preventable baby deaths) became a catalyst for change across the Victorian public hospital System?

https://www.sciencedirect.com/science/article/abs/pii/S1322769621000962

2. What can we learn from another jurisdiction's scoping study of safe staffing guidelines?

https://www.nice.org.uk/guidance/NG4/documents/safe-m

3. What are the views of rural and regional maternity managers and educators' views of the Maternity and Newborn Emergencies (MANE) education program in Australia, and how applicable could it be to the Tasmanian context? https://bmchealthservres.biomedcentral.com/arti

Recommended reading

I recently enjoyed reading a book called The Unexpected. Navigating pregnancy during and after complications by Emily Oster and Dr Nathan Fox, Penguin, 2024. Emily Oster is the author of Crib Sheet and Expecting Better.

The reason that I enjoyed it is that the book offers an accessible decision-making model for women experiencing feelings of unpreparedness for pregnancy, birth, and when planning a pregnancy after prior complications. Medical and obstetric jargon is demystified. The book offers understanding of maternal health complications, relevant data for each complication, and an attempt to offer two key questions: 1. What is the risk of recurrence in a later pregnancy? and 2. What treatments might lower that risk? 3. A third question is also considered: 3. How can I better prepare if it does happen again? The book's strength is that it can contribute to empowering women and their partners on approaching conversations with health care providers. The book offers open discussion of pregnancy complications with the additional benefits of reducing feelings of anxiety and guilt by normalising feelings.

Ms Amanda Singleton (correction)

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Conclusion

Thank you for your efforts to consider the concerns of Tasmania's valued midwives and to enhance the status of Tasmania's women so that birthing mothers are safe, heard, valued, and respected.

Competing interests or conflict of Interest Statement

I am not currently employed by the Tasmanian Government or the Tasmanian Department of Health. All the articles cited are available by googling online. *As a member of the Tasmanian branch of the National Council of Women I have no conflicts of interest.*

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Yours sincerely

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